(3)

No. 08-1585

Supreme Court, U.S.
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In The

Supreme Court of the United States

EVELYN S. HARRIS,

Petitioner,

v.

THE STANDARD INSURANCE COMPANY and MCNEES, WALLACE, & NURICK WELFARE BENEFIT PLAN,

Respondents.

On Petition For Writ Of *Certiorari* To The United States Court Of Appeals For The Ninth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

LISA ELAYNE LEAR
Counsel of Record
KATHERINE M. SOMERVELL
BULLIVANT HOUSER BAILEY PC
300 Pioneer Tower
888 SW Fifth Avenue
Portland, OR 97204-2089
(503) 228-6351

Attorneys for Respondents

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTIONS PRESENTED

1. Has Petitioner established an existing conflict among the Circuits regarding the need to disclose information developed during the administrative appeal process for claims under the Employee Retirement Income Security Act of 1974[1] ("ERISA") involving disability benefits and a Plan Administrator with a structural conflict-of-interest?

2. Has Petitioner established a relevant conflict among the Circuits regarding the ability of District Courts to consider evidence beyond the administrative record based on allegations that (a) the Plan Administrator failed to satisfy the minimum regulatory requirements for handling ERISA claims, and (b) the alleged errors affected the record subject to administrative review, such that there is a need for further guidance from this Court on how to apply its decision in *Metropolitan Life Ins. Co. v. Glenn*, ___ U.S. ___, 128 S.Ct. 2343 (2008), or the Department of Labor's regulations governing disability claims?

3. Has Petitioner established a basis for this Court to exercise its supervisory powers to step in and define what constitutes (a) the "full and fair review" provided for by the regulations governing ERISA claims, or (b) the "higher than marketplace" duty discussed in *Metropolitan Life Ins. Co. v. Glenn*, *supra*?

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[1] 29 U.S.C. §1001, *et seq*.

CORPORATE DISCLOSURE STATEMENT

Respondent Standard Insurance Company is a wholly-owned subsidiary of Stancorp Financial Group, Portland, Oregon, which is publicly traded on the New York Stock Exchange.

Respondent McNees, Wallace & Nurick Welfare Benefit Plan is an ERISA plan and is not a corporation.

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INTRODUCTION

Petitioner Evelyn S. Harris ("Petitioner") asks this Court to grant *certiorari* and review the decision of the United States Court of Appeals for the Ninth Circuit,[2] which affirmed the decision of the United States District Court for the District of Oregon[3] adopting the Findings and Recommendations of a Magistrate Judge.[4] The Magistrate and District Court had upheld the decision by Respondent The Standard Insurance Company ("Standard") denying Petitioner's claim for long-term disability benefits under Respondent McNees, Wallace & Nurick Welfare Benefit Plan ("the Plan"). Petitioner contends that review is necessary to resolve two alleged conflicts among the Circuit Courts and to "define and apply" (a) ERISA's mandate to provide "full and fair review" for handling disability claims, and (b) what constitutes the "higher than marketplace" duty imposed on "dual-role" Plan Administrators under this Court's decision in *Metropolitan Life Ins. Co. v. Glenn*, *supra*. This Court should deny the Petition because the first claimed conflict does not exist, the second claimed conflict, if it does exist, is not relevant to this case, and, in any event, the concern Petitioner raises is answered by this Court's decision in *Glenn*.

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[2] App. 1a.

[3] App. 5a.

[4] App. 7a.

STATEMENT OF THE CASE

A. Petitioner's Disability Claim and the Plan Administrator's Determination

Petitioner was employed by the law firm McNees, Wallace & Nurick as an estate planning attorney from April 2001 until June 2002, when Petitioner quit her job and negotiated her withdrawal from the firm. App. 9a-10a, 13a. One of the benefits provided by the firm was the Plan, which included long-term disability benefits pursuant to a group Long-Term Disability Policy issued by Standard. The Plan provided that to be eligible for long-term disability benefits, a claimant must remain continuously disabled under the terms of the Plan throughout the benefit-waiting-period (*i.e.*, for 180-days following the onset of a disability). App. 9a-10a. The Plan defined "disability" as:

> During the Benefit Waiting Period and the Own Occupation Period you are required to be Disabled only from your Own Occupation.
>
> You are Disabled from your Own Occupation if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder:
>
> 1. You are unable to perform with reasonable continuity the Material Duties of your Own Occupation; and
>
> 2. You suffer a loss of at least 20% in your indexed Predisability Earnings when working in your Own Occupation.

App. 10a.

In January 2003, following the 180-day waiting period, Petitioner filed a claim for long-term disability benefits under the Plan, claiming that she became disabled from performing her own occupation as an attorney based on two conditions – chronic fatigue syndrome ("CFS") and fibromyalgia – which Petitioner stated began in October 2001. Petitioner identified her attending physicians as Dr. Jacob Teitelbaum, Dr. Megan Borror, and Dr. John Nipple. App. 14a-15a; A.R. 197-99.[5]

Medical records from Petitioner's general practice physician – Dr. Borror – reflected that in October 2001, Petitioner complained of symptoms of moodiness, irritability, and fatigue. Dr. Borror noted that Petitioner had been going through perimenopause and had "gone through a lot" during the prior year, including changing jobs, her father's death, and her only son leaving for college. Dr. Borror concluded that Petitioner's symptoms likely were related to a combination of changes in hormone levels and the recent stress in her life, and that Petitioner's condition probably would be a "short term thing." Dr. Borror prescribed hormone replacement therapy to treat Petitioner's symptoms. App. 11a; A.R. 327-28.

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[5] "A.R." refers to the Administrative Record filed in this action. The Magistrate cited to the A.R. in his Findings and Recommendations, and the A.R. contains the facts not discussed in detail in the Magistrate's Findings.

In December 2001, Petitioner reported to Dr. Borror that Petitioner's prior problems – inability to sleep through the night, moodiness, and irritability – plus her depression all were under control. When Petitioner saw Dr. Borror later that month, Petitioner reported that things had improved significantly, she was able to concentrate on work, and she no longer had significant mood swings or irritability. Petitioner said she was getting through her work day just fine and no longer got physically sick when she looked at her workload. Dr. Borror noted that Petitioner's affect was full and normal, and she did not seem anxious. App. 11a-12a; A.R. 329.

Dr. Borror's records showed that Petitioner's condition began to worsen again in May 2002, when Petitioner reported that she was experiencing problems with "decreased energy, sense of being tired, not having energy to get out of chair. Low ambition, no drive." App. 12a. Petitioner reported feeling "physically achy" after she had worked in her garden. She told Dr. Borror that she believed some of her symptoms were related to depression, noting that she was dealing with issues at work and was upset by her college-age son "testing her limits." Petitioner also reported that she had reached the point where she needed to make a decision about "where she was going" with her job and whether she wanted to continue working full-time or cut back. Dr. Borror advised Petitioner to reduce her alcohol consumption and change the time of day she took the Effexor

Dr. Borror had prescribed for Petitioner's depression. App. 12a; A.R. 330-31.

In June 2002, just two weeks before quitting her job, Petitioner reported that she still suffered from decreased energy and a loss of ambition, noting that since she started taking Effexor, she had problems she had not had before, such as making mistakes when dictating letters and speaking, using words she had not planned to use, and having days when she could not face going to work. Dr. Borror advised Petitioner to taper off the Effexor. App. 12a-13a.

Dr. Borror referred Petitioner to Dr. John Nipple to evaluate whether there were any physical causes for her symptoms. Dr. Nipple performed several tests, all of which were normal with the exception of a low vitamin B-12 level. Dr. Borror recommended monthly vitamin B-12 injections. App. 13a.

When Petitioner returned to Dr. Borror in September 2002, Petitioner reported that since she had stopped working, she felt significantly better. Petitioner believed her problems were directly related to her job and the practice of law, and Petitioner did not know whether she would ever return to practicing law. App. 13a. In November 2002, Petitioner told Dr. Borror that Petitioner was "100% better, feels better than she has felt in years." App. 14a. Petitioner said she enjoyed being off work, taking care of her home, and spending time with her sisters and mother. Petitioner had no problems with her appetite or stomach, and was enjoying life. Dr. Borror concluded

that Petitioner's adjustment disorder and depressed mood were "much better since leaving job, I think she made big turnaround." App. 14a.

In December 2002, Petitioner asked Dr. Borror to fax Petitioner's medical records to Dr. Jacob Teitelbaum, a specialist in CFS. Petitioner then saw Dr. Teitelbaum for the first time. His report differs markedly with Dr. Borror's report from just one month earlier. Dr. Teitelbaum diagnosed Petitioner with myofascial pain syndrome, with a secondary diagnosis of CFS. His notes indicate that Petitioner had severe fatigue, pain and cognitive dysfunction associated with myofascial pain syndrome and CFS, together with severe sleep disorder. Dr. Teitelbaum opined that Petitioner was unable to perform her job as an attorney because of those symptoms, and attempting to work would likely cause Petitioner's symptoms to flare and risk leaving her bed-ridden with CFS and unable to do activities of daily living. Dr. Teitelbaum concluded that Petitioner was "100% disabled from her current occupation." App. 14a; A.R. 196, 459.

In January 2003, six months after she left work, Petitioner applied for long-term disability benefits, describing her illness as CFS with Immune Dysfunction Syndrome/Fibromyalgia, and her symptoms as fatigue, chronic pain, and reduced ability to concentrate. App. 14a-15a. Standard referred Petitioner's file to consulting rheumatologist Dr. Shirley Ingram for review. In April 2003, Dr. Ingram issued a report questioning Dr. Teitelbaum's diagnoses, noting that

CFS is a diagnosis of exclusion and that the medical community agrees that CFS is not a tenable diagnosis in the presence of depression, which has identical symptoms. Dr. Ingram noted the absence of pain symptoms in Petitioner's medical records and that Dr. Teitelbaum never diagnosed Petitioner with fibromyalgia. Dr. Ingram also was concerned that, on Dr. Teitelbaum's recommendation, Petitioner was taking 24 different medications and supplements, which created a great risk of drug interaction and oversedation. Finally, Dr. Ingram questioned Dr. Teitelbaum's plan not to see Petitioner again for five months if his diagnosis was accurate. Based on her review of Petitioner's records, Dr. Ingram concluded that the medical evidence supported a diagnosis of depression, for which Petitioner had received appropriate treatment from Dr. Borror, and that Petitioner's condition had sufficiently improved by November 2002 to allow her return to work. Dr. Ingram recommended that Standard obtain records of any psychiatric or neurocognitive tests, ***if any had been done***. App. 15a-16a.

Standard sent Petitioner a letter dated April 25, 2003, denying her claim for long-term disability benefits on the ground that she had not shown she was totally disabled throughout the 180-day benefit-waiting-period ending December 26, 2002. Standard explained its decision in detail, discussing the relevant plan requirements, identifying the medical information on which Standard relied, the basis for

its conclusions, and Petitioner's right to appeal Standard's decision. App. 16a, 45a-49a; A.R. 355-62.[6]

Petitioner appealed Standard's denial by letter dated July 21, 2003, enclosing additional documentation. App. 16a; A.R. 461-63. Petitioner provided her patient files from Drs. Patel and. Rastogi,[7] as well as articles on the effective treatment of fibromyalgia and myofascial pain syndrome. Petitioner also included a letter from Dr. Teitelbaum stating his continued belief that Petitioner was completely disabled from virtually all activity. App. 16a-17a.

Because Petitioner's appeal appeared to suggest bad faith or some procedural irregularity on Standard's part, Standard sent Petitioner's file and her July 2003 letter back to the original claims specialist and consulting physician for further review.[8] Dr.

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[6] Petitioner included limited portions of that letter in her Appendix.

[7] Dr. Patel diagnosed Petitioner with mild macrocytic anemia, which he opined was likely due to her alcohol intake. Dr. Patel advised Petitioner to cease all alcohol consumption for two weeks. He also expressed surprise that Dr. Teitelbaum had Petitioner taking 24-27 different medications. App. 16a-17a.

Dr. Rastogi, an internist, saw Petitioner only once. Although Dr. Rastogi appeared to have diagnosed Petitioner with CFS, hemochromatosis, and fibromyalgia, her testing did not reveal any data to support such diagnoses. App. 17a.

[8] Contrary to Petitioner's statement (Pet. 23), that was ***not*** the administrative review contemplated by 29 C.F.R. §2560.503-1(h)(3)(ii) and (iv). Instead, it was an extra step Standard undertook voluntarily to ensure no errors had been made in the initial evaluation. Although Standard was not required to do so, it

(Continued on following page)

Ingram concluded that the additional information did not support the existence of any condition that would have precluded Petitioner from returning to work in November 2002. App. 17a.

After concluding that the new information did not change the initial evaluation done in April, Standard forwarded Petitioner's entire claim file to the "Quality Assurance Unit" for an independent review. App. 17a. Standard also sent Petitioner a letter, dated September 24, 2002, advising Petitioner that the file had been forwarded to the Quality Assurance Unit, following review by the original claims specialist. Standard repeated that Petitioner's medical records did not support a diagnosis of CFS or fibromyalgia, adding that Dr. Teitelbaum's methodology did not comport with standard rheumatologic evaluation and was not supported by standard scientific reasoning, and his treatment was not generally accepted within the medical community. Finally, Standard noted the absence in Petitioner's records of any neuropsychiatric evaluations or other documentation of cognitive impairment. App. 17a-18a, 50a-55a.

The Quality Assurance review was handled by a new claims specialist, who consulted with Dr. Bradley Fancher, Board Certified in Internal Medicine. In an

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notified Petitioner that Standard had undertaken this additional step before sending the file on for the independent review called for by the regulations. App. 17a-18a.

October 2003 report, Dr. Fancher noted that prior to meeting Dr. Teitelbaum in December 2002, Petitioner's history was primarily one of moodiness, irritability, and depression. Dr. Fancher questioned Dr. Teitelbaum's diagnosis of CFS due to insufficient evidence, especially where there was no indication that Dr. Teitelbaum had reviewed Petitioner's medical records, taken a mental health history, or conducted a mental health examination or cognitive testing. Dr. Fancher found the diagnosis of fibromyalgia similarly curious where Dr. Teitelbaum admitted that Petitioner did not have 11 of the 18 "trigger points" commonly required to support such a diagnosis. Dr. Fancher noted that all of Petitioner's lab results were normal, other than an elevated MCV which Dr. Rastogi attributed to Petitioner's alcohol consumption. Dr. Fancher concluded that the medical records supported a diagnosis of adjustment disorder associated with depression, but did not demonstrate a physical or mental condition that would have kept Petitioner from working throughout the entire benefit-waiting-period. App. 18a-19a.

Standard sent Petitioner a letter dated October 23, 2003 making final the decision denying her claim for long-term disability benefits. App. 19a. Standard set out the reasons for its conclusion that Petitioner did not have fibromyalgia, adding that such a condition and other pain syndromes do not disable a person from performing the sedentary to light-level work done by attorneys. Standard explained that Petitioner's diagnosis of depression or adjustment

disorder would account for her symptoms of fatigue and precluded a diagnosis of CFS. Standard concluded that Dr. Borror's November 5, 2002 chart note documenting Petitioner's own report of her significantly improved condition demonstrated that Petitioner had not been ***continuously disabled*** throughout the benefit-waiting-period. Finally, Standard advised Petitioner of her right to obtain documents in her file free of charge, and to seek judicial review. App. 19a, 56a-59a.

B. Petitioner's ERISA Action and the District Court's Rulings

Petitioner filed this action, alleging that Standard had violated ERISA and breached its fiduciary duty by improperly denying Petitioner's claim for long-term disability benefits. App. 7a-8a. Respondents denied Petitioner's claims and alleged, *inter alia*, that Petitioner's entitlement to benefits was limited by the terms of Standard's Long-Term Disability Policy, and that Standard complied with, and performed, all of its promises, obligations, and duties under ERISA and the terms of the Plan.

Both sides moved for summary judgment. App. 8a. Respondents contended that the Plan conferred discretion on Standard to administer the Plan and make final benefits determinations, and that Standard had not abused its discretion in denying Petitioner's claim because the decision was both reasonable and supported by substantial evidence in

the administrative record. Petitioner contended that Standard had committed "flagrant violations" of ERISA regulations by depriving her of an understanding of what she needed to submit to "perfect her claim."

Petitioner also submitted additional evidence that she had not submitted during the administrative proceeding. Petitioner urged the District Court to (a) consider the additional evidence, and (b) allow Petitioner to obtain through discovery still more evidence that she claimed she needed to cure Standard's alleged failure to comply with its fiduciary obligations and applicable ERISA regulations. App. 33a-34a.

Respondents moved to strike Petitioner's "extra-record" evidence, noting that she was not entitled to rely on evidence outside the Administrative Record. Respondents argued that Standard provided Petitioner all the information she was entitled to at all appropriate times. App. 34a. Petitioner opposed the motion to strike, arguing that Standard had an obligation to provide, in language Petitioner could understand, notice regarding the kind of evidence needed to perfect her claim and that because Standard failed to do so, Petitioner was entitled to present evidence outside the Administrative Record to cure any defects resulting from the alleged procedural violations.

A Magistrate Judge entered Findings and Recommendations in favor of Respondents, stating, *inter alia*:

> [T]his Court concludes Standard committed no procedural errors in processing [Petitioner's] claim, and thus that its decision to deny [Petitioner's] benefits may be reviewed for abuse of discretion only. The Court further concludes that, in light of Standard's structural conflict of interest, its benefits decision must be reviewed with a cognizable but low level of skepticism.
>
> ....
>
> The existence of evidence in the record that would have supported a contrary conclusion is not evidence of abuse of discretion.... Because there was a factual basis in the record to support Standard's decision, and because Standard's decision was reasonable in light of that factual basis, this court must conclude that Standard did not abuse its discretion in denying benefits to [Petitioner].

App. 21a, 38a. Petitioner objected to the Findings and Recommendations, arguing that the Magistrate's Order rested on a finding that Standard had not violated ERISA's minimum requirements, which was contrary to the facts and the applicable statutes, regulations, and case law. Respondents opposed Petitioner's objections, pointing out that her challenges rested on the erroneous assumption that Standard had denied her claim for the sole reason that she had

failed to submit evidence of neurocognitive deficits, but that Standard's decision actually was based on affirmative evidence that her condition had improved to the point where she did not remain totally disabled during the entire benefit-waiting-period.

After reviewing Petitioner's objections, the Magistrate's Findings and Recommendations, and the summary judgment record, the District Court Judge agreed with the Magistrate:

> This Court has carefully considered [Petitioner's] Objections and concludes that they do not provide a basis to modify the Findings and Recommendations. The Court also has reviewed the pertinent portions of the record *de novo* and does not find any error in the Magistrate Judge's Findings and Recommendations.

App. 6a. The District Court adopted the Magistrate's Findings and Recommendations, granted Respondents' motion for summary judgment, and entered a Judgment dismissing Petitioner's claims.

C. The Ninth Circuit's Decision

Petitioner appealed to the Ninth Circuit, contending that the District Court erred in upholding Standard's determination because (1) Standard failed to provide the "full and fair review" required by ERISA; (2) the Court failed to treat Standard's second denial letter as an "adverse benefit determination on review" subject to certain ERISA regulations; (3) the

Court failed to impose *de novo* review due to Standard's "flagrant violations" of ERISA regulations; and (4) the Court failed to consider the Petitioner's additional evidence offered to address gaps created by Standard's violations of the minimum procedural requirements. Standard contended that there was no basis to impose a standard of review other than abuse of discretion or to admit evidence not included in the administrative record. Standard also argued that the District Court properly ruled that Standard had not abused its discretion in denying Petitioner's claim where Standard reasonably relied on the opinions from its physician consultants, Standard's determination was both reasonable and well supported by the administrative record, and the diagnosis by Petitioner's physician (who came very late to the table) was questionable and not dispositive of disability.

The Ninth Circuit rejected the argument that Standard committed "flagrant violations" of ERISA regulations and also rejected the contention that Petitioner was entitled to *de novo* review. Instead, the Plan Administrator's structural conflict was one of the factors to be considered in evaluating the claim. App. 2a, *citing Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006).

The Ninth Circuit did find one error in the District Court's decision – the Ninth Circuit concluded that Standard had erred in including in its

"interim" denial letter[9] an additional reason for denying Petitioner's claim. The Ninth Circuit concluded, therefore, that the District Court should have considered Petitioner's additional evidence. App. 3a. The Ninth Circuit went on to consider that evidence. After doing so, however, the Ninth Circuit affirmed the lower court's decision upholding Standard's determination that Petitioner had not presented evidence that she had been disabled throughout the entire benefit-waiting-period. App. 3a-4a.

REASONS FOR DENYING THE WRIT

A. Petitioner failed to establish a Circuit split or any other issue justifying Supreme Court review.

1. The standard of review for determinations by Plan Administrators with structural conflicts-of-interest remains abuse of discretion.

This Court made clear nearly 20 years ago the standards of review applicable when district courts review decisions regarding benefits under employee benefit plans:

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[9] The "interim" denial letter referred to the letter Standard sent Petitioner after Standard asked the original claim specialist and medical expert to review their determinations when Standard received Petitioner's administrative appeal of that determination. That was the extra step Standard was not required to take, but did so voluntarily in order to avoid errors.

> Consistent with established principles of trust law, we hold that a denial of benefits challenged under §1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.... Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a "facto[r] in determining whether there is an abuse of discretion."

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989), *quoting Restatement (Second) Trusts* §187, *comment d* (1959). This Court recently reaffirmed that analysis in *Metropolitan Life Ins. Co. v. Glenn*, *supra*, where the claimant sought benefits under a long-term disability plan. MetLife had granted Glenn's initial application, concluding that she met the plan's requirements for the initial 24 months of benefits. However, to qualify for benefits beyond 24 months, Glenn had to meet a stricter standard, which MetLife concluded she failed to meet. The district court ruled that MetLife had not abused its discretion in reaching that determination, but the Sixth Circuit reversed. In doing so, the Sixth Circuit took into account MetLife's structural conflict-of-interest – MetLife both evaluated claims and paid benefits on accepted claims – as a factor to be weighed in determining whether MetLife had abused its discretion. 128 S.Ct. at 2346-47.

MetLife challenged the Sixth Circuit's application of *Firestone*, arguing that the Court had erred in applying MetLife's conflict. *Id.* at 2349-50. After holding that the Sixth Circuit properly considered the conflict, this Court explained how such conflicts should "be taken into account on judicial review of a discretionary benefit determination." *Id.* at 2350. In doing so, this Court rejected the notion that including the conflict in the evaluation amounts to using some standard of review other than abuse of discretion:

> We do not believe that *Firestone*'s statement implies a change in the standard of review, say, from deferential to *de novo* review. Trust law continues to apply a deferential standard of review to the discretionary decisionmaking of a conflicted trustee, while at the same time requiring the reviewing judge to take account of the conflict when determining whether the trustee, substantively or procedurally, has abused its discretion.

Glenn, 128 S.Ct. at 2350, *citing Restatement (Second) Trusts* §187, *comments d-j*; §107, *comment f.* The Court added that it is neither "necessary or desirable" for courts to establish special rules for burden-of-proof or other procedural or evidentiary rules that focus on the evaluator/payor conflict in ERISA benefit determinations. Because the conflict is "but one factor among many that a reviewing judge must take into account," and because benefit determinations arise in varied circumstances that each affect, in their own way, the degree of seriousness of the conflict, courts

must not attempt to develop a one-size-fits-all procedural system for conducting judicial review of benefit determinations. *Glenn*, 128 S.Ct. at 2351.

Instead, this Court made clear in *Glenn* that it meant what it said about the conflict in *Firestone* – the conflict is but one factor the judge takes into account and weighs together with other factors appropriate for the circumstances, in determining whether the plan administrator abused its discretion. The task is like those the judge undertakes in many other judicial decisions, assigning to each factor its inherent or case-specific importance under the circumstances. *Glenn*, 128 S.Ct. at 2351.[10] This Court affirmed the Sixth Circuit's decision to reverse MetLife's determination because the Sixth Circuit had applied the "combination-of-factors" method of review. The lower court gave the conflict weight to some degree, indicating that it would not have found the conflict, by itself, to be determinative. *Id.* at 2351-52.

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[10] Indeed, the Court made clear that its discussion of the *Firestone* elements (*see* 128 S.Ct. at 2347-48) did ***not*** constitute a detailed set of instructions and, instead, the Court warned that attempting to create formulas would "'falsif[y] the actual process of judging' or serve as 'instrument[s] of futile casuistry.'" *Id.* at 2352.

That statement answers Petitioner's erroneous charge that this Court should accept review and "amplify and implement its holding and the Department of Labor's intent that our judicial system must follow a uniform procedure and method in reviewing ERISA benefits claim decisions." (Pet. 16) Instead, each case must be handled based on its own circumstances.

In this case, although neither the Magistrate nor the District Judge had the benefit of this Court's decision in *Glenn*, the Magistrate engaged in an analysis similar to that used by the Sixth Circuit in *Glenn*. As noted, Standard's Plan delegates discretion and, therefore, Standard acted under a structural conflict-of-interest.[11] App. 20a-21a. The Magistrate noted the standards established in *Firestone*, that Standard had a structural conflict-of-interest, and that it was appropriate to review Standard's benefits determination for abuse of discretion. App. 20a-21a, 32a-33a.

Petitioner asks this Court to provide guidance on the meaning, *inter alia*, of the "higher than market-place" obligations imposed by ERISA statutes and regulations on a Plan Administrator's performance of its duty to conduct a "full and fair review" of adverse

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[11] Standard's Plan provides:

> Except for those functions which the Group Policy specifically reserves to the Policy owner or Employer, we have full and exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy.

App. 20a-21a. The Ninth Circuit previously had held that the same language constitutes a delegation of discretion. *Bendixen v. Standard Ins. Co.*, 185 F.3d 939, 943 (9th Cir. 1999). Here, as in *Abatie*, the District Court's review properly was "informed by the nature, extent, and effect on the decision-making process of any conflict of interest that may appear in the record." 458 F.3d at 967.

benefits decisions, as well as the duty to provide notice of the right to appeal. (Pet. 14) In making that argument, Petitioner quotes language from *Glenn* discussing the "higher-than-marketplace quality standards" imposed on insurers under ERISA. This Court used that language to explain that ERISA imposes higher standards on Plan Administrators than are imposed on insurers generally, and supplements the marketplace and regulatory controls on insurers with judicial review of individual claim denials. 128 S.Ct. at 2350. Nothing in that analysis changes the fact that the District Court's standard-of-review remains abuse-of-discretion.

2. No split exists among the Circuits regarding the 2000 ERISA regulations that merits this Court's attention.

Petitioner contends that this case involves two splits among the Circuits that have not been addressed by this Court and that merit this Court's attention: (a) the meaning and implementation of ERISA regulations that create standard minimum procedures for "full and fair review" to guide claims processing, and (b) the remedies available for violations of those minimum requirements. (Pet. 8) In raising those challenges, Petitioner overstates the nature of the alleged problem in this case, and overstates what she claims is a conflict of interest based on pre-*Glenn* cases that are no longer good law.

a. No post-amendment Circuit split exists regarding the need to disclose information developed during the administrative appeal process.

Petitioner contends there is a split among the Circuits regarding the obligations of ERISA Plans or Insurers to disclose information prior to the filing of a lawsuit. She argues that the Eighth and Ninth Circuits require Plans and Insurers to disclose information developed during the administrative appeal process, while the Tenth and Eleventh Circuits hold that the only information the Plan or Insurer must disclose is information developed before the initial denial. (Pet. 15, 17-21) Petitioner misreads some of the cases, and fails to recognize that the cases requiring disclosure all deal with pre-amendment claims.

Petitioner quotes at length from *Abram v. Cargill, Inc.*, 395 F.3d 882 (8th Cir. 2005), acknowledging that *Abram* construes the regulations as they existed ***before*** the 2000 amendments. (Pet. 17-18) Those were significant changes to the regulations, and the Eighth Circuit no longer requires the Plan or Insurer to disclose information learned during the administrative appeal process. *See Midgett v. Wash. Group Intern. Long Term Disability Plan*, 561 F.3d 887, 896 (8th Cir. 2009), which notes that the Department of Labor's 2000 amendments distinguish between the documents and records "relevant to the claimant's claim for benefits" [29 C.F.R. §2560.503-1(i)(5)] and the records to be made available to a

claimant in the case of "an adverse benefit determination on review" [29 C.F.R. §2560.503-1(j)(3)-(5)]. The Eighth Circuit explained that by including the language "on review" in subsection 2560.503-1(j)(5), the Department differentiated the initial "adverse benefit determination" from later internal appeals of that decision. *Midgett*, 561 F.3d at 895.

Petitioner cited *Midgett* only in a footnote, noting that after the 2000 amendments, the "full and fair review" in the Eighth Circuit does not include reviewing and rebutting, prior to a determination on an administrative appeal, determinations made at the same level of appeal. 561 F.3d at 896. Petitioner acknowledges that *Midgett* brings the Eighth Circuit in line with the Tenth and Eleventh Circuits, both of which require disclosure only of information gathered or learned during the initial administrative proceeding. *Metzger v. UNUM Life Ins. Co. of America*, 476 F.3d 1161, 1166 (10th Cir. 2007);[12] *Glazer v.*

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[12] The Tenth Circuit explained:

> Permitting a claimant to receive and rebut medical opinion reports generated in the course of an administrative appeal – even when those reports contain no new factual information and deny benefits on the same basis as the initial decision – would set up an unnecessary cycle of submission, review, re-submission, and re-review. This would undoubtedly prolong the appeal process, which, under the regulations, should normally be completed within 45 days. 29 C.F.R. §2560.503-1(i)(3)(i).

476 F.3d at 1166. The District Court had reached a similar conclusion, ruling that subsection (h)(2)(iii) requires Plan

(Continued on following page)

Reliance Standard Life Ins. Co., 524 F.3d 1241, 1245-46, (11th Cir.), *cert. denied*, 129 S.Ct. 646 (2008).[13]

Petitioner argues that there still is a conflict between the Ninth Circuit and the Eighth, Tenth, and Eleventh Circuits. She attempts to rely on what she contends is a rule in the Ninth Circuit requiring Plan Administrators to disclose all material developed pre-suit as part of the "meaningful dialogue" guaranteed by ERISA. Petitioner cites *Booton v. Lockheed Medical Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997) and *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863 (9th Cir. 2008) as support for her argument. (Pet. 15, 19-21) Petitioner

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Administrators to release only documents relied on in the initial benefit determination – *i.e.*, before the claimant took an administrative appeal. However, documents generated during the administrative appeal process must be made available only ***after*** the Plan Administrator reaches its final decision on appeal. *Id.*

[13] The Eleventh Circuit explained that Subsection (h)(2)(iii) requires the Plan Administrator to produce all "relevant" documents, which are defined as documents that were "relied upon" or "submitted, considered, or generated in the course of making the benefit determination." 29 C.F.R. §2560.503-1(m)(8)(i)-(ii). Because the insurer had not relied on the reports the claimant sought or used in the course of making a benefit determination until that determination had, in fact, been made, there was no obligation to turn over that information to the claimant until after that determination was made. Thus, documents generated or used ***during*** the administrative appeal process did not have to be turned over until after the final decision on appeal was made. 524 F.3d at 1245.

reads more into those Ninth Circuit decisions than the Court stated.

As Petitioner acknowledges (Pet. 19), *Booton*, like *Abram*, addressed the pre-2000 amendment version of the ERISA regulations. Petitioner quotes language from *Booton* concerning the need to engage in "meaningful dialogue" with the claimant, arguing that such language requires disclosure of material developed pre-suit. (*Id.*) However, the "meaningful dialogue" identified by the Ninth Circuit was found in the pre-2000 amendments to the ERISA regulations, which identified four kinds of information the Plan Administrator must provide to a claimant, in language that could be understood by a claimant, whenever a claim was denied:

> (1) The specific reason or reasons for the denial; (2) Specific reference to pertinent plan provision on which the denial is based; (3) A specific description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and (4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

110 F.3d at 1463, *discussing* 29 C.F.R. 2560.503.1(f) (1997). *Booton* involved an insurer who failed to explain the reason for its decision or to request needed medical information; *Booton* did not involve an insurer who failed to provide claimant with

information the insurer developed during the administrative appeal process (*i.e.*, after the initial adverse determination but before the final decision is made on an administrative appeal). Thus, nothing in *Booton* addressed the issue for which Petitioner attempts to use it as authority.

The same is true for *Saffon* – which also involved the pre-2000 amendments to the ERISA regulations.[14] In *Saffon*, after discussing the appropriate standard of review, the Ninth Circuit repeated the "meaningful dialogue" language from *Booton*, and discussed the history of MetLife's analysis of a claim for long-term disability benefits. After paying short-term benefits and then granting the claimant long-term disability benefits, MetLife asked a physician to review claimant's medical records. Dr. Thomas found that claimant's file "lacks detailed objective, functional findings or testing which would completely preclude" an effort to return to work. 522 F.3d at 869. MetLife forwarded Dr. Thomas' report to claimant's neurologist, who sent MetLife a detailed letter discussing claimant's reported symptoms, the neurologist's unsuccessful efforts to alleviate them, and "[o]bjective evidence of cervical pathology." *Id.* The claimant also

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[14] Although *Saffon* was a 2008 decision, it involved events from December 2001, resulting in claimant stopping work and applying for disability benefits. 522 F.3d at 866. The 2000 amendments to the ERISA regulations applied to claims filed on or after the first day of the plan year beginning on or after July 1, 2002, but no later than January 1, 2003. 64 Fed. Reg. 70,246 (Nov. 21, 2000).

responded with a letter explaining her condition. MetLife sent the two letters back to Dr. Thomas for a second review. He again concluded that the file "lacks clear, sequential, detailed, objective clinical information which would completely preclude [claimant] from an attempt at return to work." *Id.* MetLife faxed that information to the neurologist, giving him 10 days to respond, but did not notify claimant. The neurologist did not respond within 10 days. MetLife then terminated claimant's benefits, notifying her she could appeal by providing

> medical evidence from doctor(s) treating you for a condition that indicates you are under the appropriate care and treatment and objective medical information to support your inability to perform the duties of your occupation.

Id. Claimant appealed, attaching her most recent MRI and another letter from the neurologist. MetLife submitted the appeal to Dr. Menotti, who read the file and concluded there were not enough "'objective medical findings and office notes that have continued to flow into this file, that convince this reviewer that the claimant's self reported headache and chronic pain syndrome has been enough to preclude her from' working." *Id.* at 869-70. MetLife denied the appeal, stating that medical information furnished with her claim indicated diagnoses of chronic headaches, chronic pain syndrome, etc., but that the determination of disability is not based on the presence of diagnoses but on functional ability supported by

clinical evidence that would substantiate symptoms consistent with those reported by the patient and medical providers. *Id.* at 870. MetLife added:

> ... It is not clear what [the neurologist] used as a basis for [his diagnosis of your] reported limitations as we've not been furnished with a Functional Capacity Evaluation that would objectively measure and document your current level of functional ability.
>
> ... The MRI of April 28, 2003 documents degenerative changes [in your cervical spine], but indicates this is unchanged from the prior January 12, 2002 MRI.

Id.

In reviewing the denial, the Ninth Circuit returned to its statement in *Booton* that the ERISA regulations called for a "meaningful dialogue" between claims administrator and beneficiary, adding that MetLife was required to give claimant a "description of any additional material or information" that was "necessary" for her to "perfect the claim," and to do so "in a manner calculated to be understood by the claimant." *Id.*, *quoting* 29 C.F.R. §2560.503-1(g). It was that requirement that MetLife failed to meet. *Id.* at 870-71. The Court did not fault MetLife

for failing to provide claimant with information developed during the pre-suit process.[15]

Again, neither *Booton* nor *Saffon* – both of which address the pre-2000 amendment regulations – establish the conflict that Petitioner attempts to establish with case law from the Eighth, Tenth, and Eleventh Circuits. Thus, Petitioner's argument (Pet. 22) that *Saffon* demonstrates the split because Standard committed the same kinds of violations as in *Saffon* based on "including new explanations for its denial of benefits in the 'interim' denial letter of September 24, 2003, without giving [Petitioner] an opportunity to then submit additional evidence relevant to those explanations" is wrong. Although a panel of the Ninth Circuit may have concluded that Standard violated the rules established in *Saffon*, that Court did ***not*** determine that there was a conflict. Indeed, Petitioner ***did not even raise the issue of a conflict among the Circuits***. That is likely due to the fact that, if one ignores the fact that the Ninth Circuit

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[15] The Ninth Circuit does address information in MetLife's termination letter regarding the absence of a Functional Capacity Evaluation that would objectively measure and document claimant's current level of functional ability. 522 F.3d at 871. That analysis addresses the prohibition against adding new grounds for denial to the final appeal determination, when it would be too late for the claimant to address. *Id.* at 871-72. Petitioner refers the Ninth Circuit's requirement that a District Court allow a claimant to present additional evidence on any newly raised issues. (Pet. 20) That is part of the second alleged conflict raised by Petitioner (*see* Pet. 25-26) and, therefore, is discussed below.

was dealing with the pre-2000 amendments to ERISA regulations while the Eighth, Tenth, and Eleventh Circuits are addressing the effect of those amendments, Petitioner benefits from the fact that the Ninth Circuit imposes more stringent requirements on Plan Administrators.

Petitioner attempts to use *Saffon* for other purposes as well, contending that other parts of *Saffon* somehow establish a conflict between the Ninth Circuit and other Circuits. In that regard, Petitioner cites the discussion in *Saffon* regarding the degree of deference to which a Plan Administrator's decision is entitled on judicial review based on the Administrator's course of dealing with the claimant, arguing that the Administrator's violations of its duty in *Saffon* were by means of "precisely the same tactics Standard used here." (Pet. 21) Petitioner attempts to compare the "opaque communications" in *Saffon* with Standard's communications with Petitioner. (*Id.*) Petitioner ignores the significant differences between the two cases. First, the requested information involves information that ***does not exist***. Contrary to Petitioner's efforts to re-characterize the facts, the relevant information involves any neuropsychological exams establishing Petitioner's status during the 180-day benefit-waiting-period. No such record exists because no such exam was done.

Petitioner also contends that Standard violated the regulations by failing to identify, in the initial denial letter, what she needed to submit to perfect her claim. She argues that Standard should have told

her that she needed to submit the results of a neuropsychological exam revealing neurocognitive impairment. That argument is based on a misreading of the regulations and elevates the importance of neurocognitive testing out of all proportion.

Contrary to Petitioner's argument, Standard's decision was ***not*** based solely on the lack of evidence of neurocognitive impairment and, therefore, Petitioner could ***not*** have remedied the problem by submitting such evidence alone. Instead, Standard denied her claim because the medical records did not reveal ***any*** impairment – physical, mental, or neurocognitive – as of November 2002.

Moreover, requiring a Plan Administrator to advise a claimant of missing information she may need to ***perfect her claim*** is not equivalent to requiring the Administrator to tell the claimant exactly what she needs to submit for her claim ***to be approved***. As the Fourth Circuit explained:

> Subsection (f)(3)[16] is only implicated when there remain unresolved, material factual questions about which a plan administrator or fiduciary must have information in order to review the denial of the claim.... [Claimant] has somehow conflated these purposes and come to the erroneous belief that MetLife is under an obligation to inform her

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[16] That provision was renumbered as (g)(1)(iii) with the 2002 revisions to the regulations.

> of what she needs to tell MetLife in order to obtain disability benefits. That is not MetLife's role as a fiduciary. MetLife must treat each claimant with procedural fairness, but, because it must also guard against improper claims, it is not its duty to affirmatively aid claimants in proving their claims.

Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 236 (4th Cir. 1997).

Standard complied with the applicable regulations. In a detailed 8-page letter, Disability Claims Specialist Steven Poindexter quoted the relevant policy provisions, summarized the medical records Standard had, and set out the opinion of Standard's physician consultant. Poindexter then concluded:

> After a complete review of your claim file, including your statements and the results from the medical file review, we find that as of November 2002 your depression had markedly improved, given your appropriate treatment from antidepressant medications as noted by Dr. Borror. Although Dr. Teitelbaum diagnosed you with Chronic Fatigue Syndrome and Myofascial Pain Syndrome in December 2002, review of the available medical records does not support this diagnosis. Furthermore, the length of time between your visits with Dr. Teitelbaum is not consistent with severe ongoing limitations and restrictions. Lastly, your fall in February of 2003 appears to be related to the combination of your medications and supplements, rather than a specific medical

> condition. As a result, we find that the information in your claim file does not provide satisfactory written proof that as a result of physical disease, injury, pregnancy or mental disorder you are unable to perform with reasonable continuity the material duties of your Own Occupation throughout the 180-day benefit waiting period ending December 26, 2002 and continuing. Therefore, your claim for LTD benefits is denied.

App. 54a-55a. Poindexter added:

> If you request a review, you will have the right to submit additional information in connection with your claim. ***Additional information, which would be helpful to a reconsideration of your claim, includes medical records or chart notes indicating that your medical condition is more severe than we previously understood*** and continues to support your inability to perform the material duties of your own occupation ***throughout the 180 day benefit waiting period*** ending December 26, 2002 and continuing.

App. 48a, emphasis added.

Although Petitioner argues that the statement was vague and did not notify her that a neuropsychological examination was needed, Poindexter described in plain terms exactly what was needed: ***any*** evidence that Petitioner's condition was more severe than indicated in Dr. Borror's records. The fact that Petitioner understood the need to submit evidence of

functional restrictions is clear from her subsequent submission of additional medical records from Drs. Teitelbaum, Rastogi, and Patel, together with journal articles describing fibromyalgia and CFS, and the notice that Social Security Administration ("SSA") had approved her disability claim. If the additional information had documented the severity of Petitioner's condition during the benefit-waiting-period, it could have supported her claim (although not necessarily assuring approval), even without neuropsychological testing.

As it was, none of the information Petitioner submitted in connection with her appeal provided contemporaneous evaluations of her condition during the relevant period. Instead, Dr. Teitelbaum relied on ***subsequent*** statements about Petitioner's condition during that period, and Drs. Rastogi and Patel simply accepted Dr. Teitelbaum's diagnoses without question.

The issue is not that Standard was seeking evidence of neurocognitive deficiencies but failed to advise Petitioner that she needed to submit such evidence; instead, the issue is that Standard was seeking ***any*** evidence that Petitioner's condition was more severe during the benefit-waiting-period than was indicated in Dr. Borror's medical records made contemporaneous to the relevant period. Despite Petitioner's attempt to narrow the issue to the lack of neurocognitive testing, Poindexter's letter adequately explained what evidence Petitioner needed submit in support of her claim and, therefore, the letter met the requirements of 29 C.F.R. §2560.503-1(g)(1)(iii).

Whether the evidence was of neurocognitive testing or something else is a non-issue, and the neurocognitive report Petitioner did submit was irrelevant because it did not (and could not) accurately assess Petitioner's functionality during the relevant period.

Petitioner states that the Ninth Circuit disagreed with that analysis and called Standard's conduct a violation of conduct outlawed in *Saffon* and *Abatie*. (Pet. 23) What the Ninth Circuit criticized was the inclusion of new explanations in the interim denial letter, thus not allowing Petitioner an opportunity to present additional evidence relevant to those matters. App. 2a. The question of raising new explanations after the initial denial is different than not communicating information learned by the Plan Administrator (although there can be overlap). More importantly, once again, (1) Petitioner has not established a Circuit split based on the post-2000 ERISA regulation amendments, and (2) to the extent this Court ignores the pre- and post-amendment differences, Petitioner is the beneficiary of stricter requirements. She has hardly established a need for this Court to address a need for greater protections.

Next, Petitioner attempts to compare Standard's reliance on Dr. Borror's statement in her chart notes about Petitioner's improvement to the discussion in *Saffon* about taking a doctor's statements "out of context or otherwise distorting it in an apparent effort to support denial" and to an authority cited by this Court in *Metropolitan Life Ins. Co. v. Glenn*, *supra*, in which a reviewing physician reports the

limits imposed on his work, including that he was instructed to use language to support denial, that he was not permitted to request additional information, and he was not allowed to help the claimant perfect her claim. [*Id.*, *citing Saffon*, 522 F.3d at 873; John H. Langbein, *Trust Law as Regulatory Law*, 101 NW. U. L. Rev. 1315, 1319 (2007).] This case is nothing like *Saffon* or the article she cites.

First, Petitioner's analysis relies on information not in the record before the Plan Administrator. The Record at that time indicated that Petitioner's condition had improved markedly and that before the end of the elimination period she was feeling better than she had in years. It was that information from Dr. Borror's chart notes that Standard's medical expert used in the analysis. Further, unlike in *Saffon*, there was no misuse of the statement – no tag end of the statement was left off, thereby distorting the meaning of the statement. Finally, unlike in *Saffon* or the article on which Petitioner attempts to rely, Standard's medical experts explained why they did not accept Dr. Teitelbaum's diagnosis, including the use of more than 20 vitamins and supplements, the fact that he had met with Petitioner so few times and did not plan to meet with her for a lengthy period of time, and that his diagnosis was not consistent with the medical tests or the other diagnoses of Petitioner's conditions. App. 46a-47a; 57a-59a.

b. Petitioner has not established a relevant Circuit split regarding whether a reviewing court should admit evidence beyond the administrative record.

Petitioner contends that there is a split among the Circuits regarding whether and to what extent a reviewing court should admit additional evidence beyond the administrative record. Petitioner cites three Ninth Circuit cases in support of that argument – *Saffon, Booton,* and *Abatie* (Pet. 15) – but later indicates that cases cited within those Ninth Circuit cases demonstrate a Circuit split because the cited cases do not permit the admission or consideration of additional evidence. (Pet. 25-26) However, the issue is not relevant for this case.

First, as discussed above, the evidence that Petitioner claims she was precluded from presenting is evidence about Petitioner's neurocognitive condition ***after*** the relevant time period. Again, following Standard's final decision on administrative review, Petitioner filed suit and sought to admit evidence outside the administrative record that she claims would have shown her neuropsychological deficit. What Petitioner continues to ignore was that what the reviewing doctor had said should have been included in the file were records of psychiatric or neurocognitive tests, if any had been done. App. 15a-16a. But none had been done. What Petitioner sought to have considered was evidence of her neurocognitive condition at a time that would not establish that she

had remained disabled throughout the benefit-waiting-period. Because the evidence she sought to have considered did not cure the defect, the questions whether such evidence should be considered, or whether there is a valid Circuit split, are not questions that this Court needs to consider.

In any event, even if Petitioner can establish that there is an existing Circuit split and that the evidence she sought to submit could somehow demonstrate her neurocognitive condition during the relevant time period, the Ninth Circuit determined both (1) that the District Court should have admitted the evidence, and (2) that the Ninth Circuit would, itself, consider the additional evidence. App. 3a. Even with that additional evidence, the Ninth Circuit still did not find a basis for rejecting Standard's determination denying Petitioner's claim for long-term disability benefits.

Petitioner erroneously contends that the Ninth Circuit failed to meaningfully consider the additional evidence. (Pet. 33) Petitioner is wrong. Again, Standard had already explained what was wrong with Petitioner's other evidence – unlike in the cases on which Petitioner relies, Standard had explained what was missing from that evidence, the conflicts in Dr. Teitelbaum's diagnosis with the objective medical tests and his treatment plan, and the absence of supporting documentation to address Petitioner's condition during the elimination period. Neither the District Court nor the Ninth Circuit had problems with Standard's explanations regarding those

matters. The fact that Petitioner disagrees with those explanations does not make them suspect.

The only area with which the Ninth Circuit had concerns was the failure to notify Petitioner of the need for reports of neurocognitive during the relevant time-period, if they existed, which led the Ninth Circuit itself to consider Petitioner's additional evidence. The Ninth Circuit then held that "Petitioner submitted no contemporaneous medical evidence of her inability to work for the entirety of the relevant six-month disability waiting period. In fact, she reported to her physician that she felt '100% better ... better than she has felt in years,' in the fifth month of the relevant period." App. 3a-4a. The Ninth Circuit adequately considered the evidence, and simply disagreed with Petitioner's analysis. That does not justify this Court granting *certiorari*.

B. Petitioner failed to establish a need for this Court to exercise its supervisory power to decide whether "full and fair review" requires more than what Petitioner received here.

Petitioner contends that while this Court's decision in *Metropolitan Life Ins. Co. v. Glenn*, *supra*, requires a weighing of a combination of factors, this Court failed to indicate how that is to be done in a way that implements "full and fair review through judicial enforcement of the regulations." (Pet. 27) Petitioner further contends that this case conflicts

with *Glenn* because a heightened scrutiny applies to a Plan Administrator performing under a conflict of interest requiring a balancing of factors to determine the impact of that conflict on the determination regarding benefits, but that (a) the Ninth Circuit failed to articulate what combination of factors it weighed, (b) the Court actually relied on only one factor – the procedural violation – and (c) the Court concluded, without explanation, that whatever violations Standard committed, they "did not rise to the 'wholesale and flagrant' level required for *de novo* review." (Pet. 27-28) As discussed above, Petitioner fails to accurately account for the history of this case.

Moreover, this Court made clear in *Glenn* that where a Plan Administrator has discretion to interpret the policy, the standard of review remains abuse of discretion. The conflict of interest is a factor to be considered in determining whether the Plan Administrator abused its discretion, and does ***not*** convert the standard to *de novo* review. 128 S.Ct. at 2347-48, 2350-51 (noting that how the conflict is to be taken into account on judicial review is that it is to be considered as a factor, which varies with the circumstances, and that if Congress had wanted to impose *de novo* review, it would have said so). This Court also clearly stated that it would ***not*** establish procedures, create burden-of-proof rules, or other procedural or evidentiary rules focused narrowly on how to handle the conflict-of-interest issues. Instead, this Court explained that district courts are well equipped to deal with such issues, just as they deal

with many other such issues in addressing claims involved in areas of trusts, credibility determinations, etc. *Id.* at 2351. Again, nothing about this case demonstrates a need to change that analysis or this Court's perspective.

CONCLUSION

For the reasons stated above, this Court should deny the Petition for Writ of Certiorari.

Respectfully submitted,

LISA ELAYNE LEAR
Counsel of Record
KATHERINE M. SOMERVELL
BULLIVANT HOUSER BAILEY PC
300 Pioneer Tower
888 SW Fifth Avenue
Portland, OR 97204-2089
(503) 228-6351

Attorneys for Respondents